EXHIBIT D1.

Exhibit 1 to Stewart Affidavit - Plaintiff Christopher McCullough's entire Jail File.

— Part 9 —

CHAMBERS CO. SHERIFF'S OFFICE
06/26/2001 19:35:01 MEDICAL SCREENING FORM PAGE 1

Booking No: 010001465 Date: 06/26/2001 Time: 19:18 Type: NORMAL
Agency to Bill: CHAMBERS COUNTY Facility: COUNTY JAIL

Inmate Name: MCCULLOUGH CHRISTOPHER CORNELIUOS Race: B Sex: M
DOB: 11/27/1972 Age: 28 SSN: 416 11 4328 Height: 5'01" Weight: 150

n 1. Is inmate unconscious?

n 2. Does inmate have any visible signs of trauma, illness, obvious pain and bleeding, requiring immediate emergency or doctor's care?

n 3. Is there obvious fever, swollen lymph nodes, jaundice or other evidence of infection that might spread through the facility?

n 4. Any signs of poor skin condition, vermin, rashes or needle marks?

n 5. Does inmate appear to be under the influence of drugs or alcohol?

n 6. Any visible signs of alcohol or drug withdrawal?

n 7. Does inmate's behavior suggest the risk of suicide or assault?

n 8. Is inmate carrying any medication?

n 9. Does the inmate have any physical deformities?

n 10. Does inmate appear to have psychiatric problems?

11. Do you have or have you ever had or has anyone in your family ever had any of the following?

n a. Allergies	n f. Fainting Spells	n k. Seizures
n b. Arthritis	n g. Hearing Condition	n l. Tuberculosis
n c. Asthma	n h. Hepatitis	n m. Ulcers
n d. Diabetes	n i. High Blood Pressure	n n. Venereal Disease
n e. Epilepsy	n j. Psychiatric Disorder	n o. Other (Specify)

Other: _____

_____

_____

12. For females only:

N/A a. Are you pregnant?

/ b. Do you take birth control pills?

/ c. Have you recently delivered?

CHAMBERS CO. SHERIFF'S OFFICE
06/26/2001 19:35:01 MEDICAL SCREENING FORM PAGE 2

Booking No: 010001465 Date: 06/26/2001 Time: 19:18 Type: NORMAL
Agency to Bill: CHAMBERS COUNTY Facility: COUNTY JAIL

Inmate Name: MCCULLOUGH CHRISTOPHER CORNELIUOS Race: B Sex: M
DOB: 11/27/1972 Age: 28 SSN: 416 11 4328 Height: 5'01" Weight: 150

13. Have you recently been hospitalized or treated by a doctor?
14. Do you currently take any non-prescription medication or medication prescribed by a doctor?
15. Are you allergic to any medication?
16. Do you have any handicaps or conditions that limit activity?
17. Have you ever attempted suicide or are you thinking about it now?
18. Do you regularly use alcohol or street drugs? YES
19. Do you have any problems when you stop drinking or using drugs?
20. Do you have a special diet prescribed by a physician?
21. Do you have any problems or pain with your teeth?
22. Do you have any other medical problems we should know about?

I HAVE READ THE ABOVE ACCOUNTING OF MY MEDICAL ASSESSMENT AND I FIND IT TO BE TRUE AND ACCURATE.

INMATE: Chris McCullough DATE: 6-26-01 TIME: _____

BOOK OFFICER: A. Dawson DATE: 6-26-01 TIME: 1928

CHAMBERS CO. SHERIFF'S OFFICE

04/21/2001 23:40:31 MEDICAL SCREENING FORM PAGE 1 OF 2

Booking No: 010000968 Date: 04/21/2001 Time: 23:32 Type: NORMAL
Agency to Bill: CHAMBERS COUNTY Facility: COUNTY JAIL

Inmate Name: MCCULLOUGH CHRISTOPHER CORNELIUOS Race: B Sex: M
DOB: 11/27/1972 Age: SSN: 416 11 4328 Height: 5'01" Weight: 150

No 1. Is inmate unconscious?

No 2. Does inmate have any visible signs of trauma, illness, obvious pain and bleeding, requiring immediate emergency or doctor's care?

No 3. Is there obvious fever, swollen lymph nodes, jaundice or other evidence of infection that might spread through the facility?

N 4. Any signs of poor skin condition, vermin, rashes or needle marks?

N 5. Does inmate appear to be under the influence of drugs or alcohol?

N 6. Any visible signs of alcohol or drug withdrawal?

N 7. Does inmate's behavior suggest the risk of suicide or assault?

N 8. Is inmate carrying any medication?

N 9. Does the inmate have any physical deformities?

N 10. Does inmate appear to have psychiatric problems?

11. Do you have or have you ever had or has anyone in your family ever had any of the following?

No	a. Allergies	N	f. Fainting Spells	N	k. Seizures
No	b. Arthritis	N	g. Hearing Condition	N	l. Tuberculosis
No	c. Asthma	N	h. Hepatitis	N	m. Ulcers
No	d. Diabetes	N	i. High Blood Pressure	N	n. Venereal Disease
No	e. Epilepsy	N	j. Psychiatric Disorder		o. Other (Specify)

Other: _____

_____

_____

12. For females only:

____ a. Are you pregnant?

____ b. Do you take birth control pills?

____ c. Have you recently delivered?

CHAMBERS CO. SHERIFF'S OFFICE
04/21/2001 23:40:31 MEDICAL SCREENING FORM

Booking No: 010000968 Date: 04/21/2001 Time: 23:32 Type: NORMAL
Agency to Bill: CHAMBERS COUNTY Facility: COUNTY JAIL

Inmate Name: MCCULLOUGH CHRISTOPHER CORNELIUOS Race: B Sex: M
DOB: 11/27/1972 Age: SSN: 416 11 4328 Height: 5'01" Weight: 150

_____ 13. Have you recently been hospitalized or treated by a doctor?

_____ 14. Do you currently take any non-prescription medication or medication prescribed by a doctor?

_____ 15. Are you allergic to any medication?

_____ 16. Do you have any handicaps or conditions that limit activity?

_____ 17. Have you ever attempted suicide or are you thinking about it now?

_____ 18. Do you regularly use alcohol or street drugs?

_____ 19. Do you have any problems when you stop drinking or using drugs?

_____ 20. Do you have a special diet prescribed by a physician?

_____ 21. Do you have any problems or pain with your teeth?

_____ 22. Do you have any other medical problems we should know about?

I HAVE READ THE ABOVE ACCOUNTING OF MY MEDICAL ASSESSMENT AND I FIND IT TO BE TRUE AND ACCURATE.

INMATE: X Chris McCullough DATE: _____ TIME: _____

BOOK OFFICER: _____ DATE: _____ TIME: _____

CHAMBERS CO. SHERIFF'S OFFICE
03/10/2001 23:51:42 MEDICAL SCREENING FORM PAGE 2 OF 2

Booking No: 010000651 Date: 03/10/2001 Time: 23:41 Type: NORMAL
Agency to Bill: CHAMBERS COUNTY Facility: COUNTY JAIL

Inmate Name: MCCULLOUGH CHRID CORNELIUS Race: B Sex: M
DOB: 11/27/1972 Age: SSN: 416 11 4328 Height: 5'01" Weight: 150

No 13. Have you recently been hospitalized or treated by a doctor?

No 14. Do you currently take any non-prescription medication or medication prescribed by a doctor?

No 15. Are you allergic to any medication?

No 16. Do you have any handicaps or conditions that limit activity?

No 17. Have you ever attempted suicide or are you thinking about it now?

yes 18. Do you regularly use alcohol or street drugs?

No 19. Do you have any problems when you stop drinking or using drugs?

No 20. Do you have a special diet prescribed by a physician?

No 21. Do you have any problems or pain with your teeth?

None 22. Do you have any other medical problems we should know about?

I HAVE READ THE ABOVE ACCOUNTING OF MY MEDICAL ASSESSMENT AND I FIND IT TO BE TRUE AND ACCURATE.

INMATE: X Chris McCullough DATE: 3/10/01 TIME: 2351

BOOK OFFICER: Anderson DATE: 3/10/01 TIME: 2351

CHAMBERS CO. SHERIFF'S OFFICE
03/10/2001 23:51:42 MEDICAL SCREENING FORM PAGE 1 OF 2

Booking No: 010000651 Date: 03/10/2001 Time: 23:41 Type: NORMAL
Agency to Bill: CHAMBERS COUNTY Facility: COUNTY JAIL

Inmate Name: MCCULLOUGH CHRID CORNELIUS Race: B Sex: M
DOB: 11/27/1972 Age: SSN: 416 11 4328 Height: 5'01" Weight: 150

_____ 1. Is inmate unconscious?

_____ 2. Does inmate have any visible signs of trauma, illness, obvious pain and bleeding, requiring immediate emergency or doctor's care?

_____ 3. Is there obvious fever, swollen lymph nodes, jaundice or other evidence of infection that might spread through the facility?

_____ 4. Any signs of poor skin condition, vermin, rashes or needle marks?

_____ 5. Does inmate appear to be under the influence of drugs or alcohol?

_____ 6. Any visible signs of alcohol or drug withdrawal?

_____ 7. Does inmate's behavior suggest the risk of suicide or assault?

_____ 8. Is inmate carrying any medication?

_____ 9. Does the inmate have any physical deformities?

_____ 10. Does inmate appear to have psychiatric problems?

11. Do you have or have you ever had or has anyone in your family ever had any of the following?

No	a. Allergies	No	f. Fainting Spells	No	k. Seizures
No	b. Arthritis	No	g. Hearing Condition	No	l. Tuberculosis
No	c. Asthma	No	h. Hepatitis	No	m. Ulcers
No	d. Diabetes	No	i. High Blood Pressure	No	n. Venereal Disease
No	e. Epilepsy	No	j. Psychiatric Disorder	____	~~o. Other (Specify)~~

Other: _____

_____

_____

12. For females only:

____ a. Are you pregnant?

____ b. Do you take birth control pills?

____ c. Have you recently delivered?

M E . I C A L I N F O R M A T I N

Chamber's County Detention Facility

Booking Number : 2000001450 Identifier : 6847
Booking Date.. : 08/22/2000 Soc. Sec. No. : 416-11-4328
Inmate Name... : MCCULLOUGH, CHRISTOPHER CORNELIUS
Sex..... : MALE Race : BLACK DOB : 11/27/1972
Height..... : 5' 11" Weight : 155 LBS. Age : 27

ALCOHOLIC INFLUENCE? NO
DRUG INFLUENCE? .... NO
BODY ABNORMALITIES? NO
LICE/VERMIN PROBLEMS? NO
BEING TREATED FOR ..
DOCTOR'S NAME .....
INSURANCE COMPANY ..
GROUP POLICY NUMBER

ANY ALLERGIES?	NO	DENTAL PROBLEMS?	NO
HEART PROBLEMS?	NO	KIDNEY PROBLEMS?	NO
DIABETES?	NO	EPILEPSY?	NO
BIRTH CONTROL?	NO	HIG BLOOD PRESSURE? .	NO
DRUG DEPENDANCY?	NO	TUBERCULOSIS?	NO
SUICIDAL?	NO	ALCOHOLIC?	NO
RESPIRATORY PROBLEMS?	NO	PREGNANT?	NO
HEMOPHELIA?	NO	PSYCHIATRIC CARE? ...	NO
VENEREAL DISEASE? ...	NO	HEPATITIS?	NO

Have you ever tested positive for HIV/AIDS? NO
Do you need immediate medical attention? NO
Are you currently taking any type of prescribed medication? NO
If so, list medication(s) :
Are you required to take this medication as prescribed for the balance of your health? NO
What effects will occur should you not receive your medication on a timely basis?

H E A L T H R E M A R K S

Inmate's Signature : x Chris McCullough

Mental [illegible]sability/Suicide Intake Sc ening

NAME : MCCULLOUGH, CHRISTOPHER CORNELIUS
DATE : 08/22/2000
FACILITY : Chamber's County Detention Facility
TIME : 14:21
SCREENING OFFICER : LYLESR2529
DOB. : 11/27/1972
OFFENSE/CHARGE(S) :
SID #:

Was inmate a medical, mental health, or suicide risk during any prior contact or confinement with department? NO If Yes, when?

Does arresting or transporting officer believe that the inmate is a medical, mental health, or suicide risk? NO

QUESTIONNAIRE FOR DETAINEE	
1. Have you ever received MHMR services or other mental health services?	NO
2. Do you know where you are?	CORRECT
3. What season is this?	CORRECT
4. How many months are there in a year?	CORRECT
5. (a) Sometimes people tell me they hear noises or voices that other people don't seem to hear. What about you?	NO
(b) If yes, ask for an explanation: "What do you hear?"	

OBSERVATION QUESTIONS	
6. Does the individual act or talk in a strange manner?	NO
7. Does the individual seem unusually confused or preoccupied?	NO
8. Does the individual talk very rapidly or seem to be in an unusually good mood?	NO
9. Does the individual claim to be someone else like a famous person or fictional figure?	NO
10. (a) Does the individual's vocabulary (in his/her native tongue) seem limited?	NO
(b) Does the individual have difficulty coming up with words to express him/herself?	NO

SUICIDE RELATED QUESTIONS / OBSERVATIONS

11. (a) Have you ever attempted suicide?	NO
(b) Have you ever had thoughts about killing yourself?	NO
If yes, When?	
Why?	
How?	
12. Are you thinking about killing yourself today?	NO
13. (a) Have you ever been so down that you couldn't do anything for more than a week? (If no, go to 14.)	NO
(b) Do you feel this way now?	NO

14. When not on drugs or drinking, have you ever gone for days without sleep or had a long period in your life when you felt very energetic or excited?	NO
15. Have you experience a recent loss or death of family member or friend or are you worried about major problems other than your legal situation?	YES
16. Does the individual seem extremely sad, apathetic, helpless, or hopeless?	NO

COMMENTS :

A SINGLE INAPPROPRIATE RESPONSE, EXCEPT AS APPROPRIATE IN A.3., INDICATES ADDITIONAL EVALUATION RECOMMENDED.

DATE RECEIVED: 3-7-03
TIME RECEIVED: 0800
RECEIVED BY: [signature]

CHAMBERS COUNTY DETENTION FACILITY
MEDICAL REQUEST FORM

NAME: Chris McCully NUMBER 6847 CELL# G DATE: 3-7-03

WHAT IS YOU MEDICAL PROBLEM: Big Toe infected

I UNDERSTAND THE CHAMBERS COUNTY DETENTION FACILITY CHARGES A CO-PAY FOR THESE SERVICES. I ALSO UNDERSTAND ALL MEDICAL SERVICES RENDERED WHILE AN INMATE WILL BE CHARGED BACK TO ME AS RESTITUTION. CO-PAYS ARE, TO SEE THE NURSE $2.00 - DOCTOR $5.00 PRESCRIPTIONS $1.00 EACH, THESE CHARGE WILL BE DEDUCTED FROM MY COMMISSARY ACCOUNT. BEING INDIGENT DOES NOT STOP ME FROM SEEKING MEDICAL ATTENTION

Chris McCully
INMATE SIGNATURE

NURSE/DOCTOR NOTES: seen

3-7-03
DATE

[signature]
NURSE/DOCTOR SIGNATURE

NURSE ✓ $2.00 DOCTOR _____ $5.00 PRESCRIPTIONS _____ AT $1.00

TOTAL INMATE CHARGES $2.00 BY: [signature]
DATE: 3.7.03 CLERK

Case 3:05-cv-01163-WKW-SRW Document 32-13 Filed 07/28/2008 Page 11 of 24

Chambers County Detention Facility Montly Medication Sheet

Code = R-Refused D/C-Discontinued O-Ordered

Last Name: McCullough | First Name: Chris | Middle Name: | Master ID#: | Room No.: H | Month: Feb | Year: 2007

Medications	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Doxepin 50 mg 1 cap at bedtime 958 251	7PM	7	7	5	5	5	5	7	7	7	7	4	25	4	25	7	7	7	D/C													
Doxepin 50 mg 1 cap at bedtime 965 253	7PM																											5				

Initial Medication and Identify Initials Below with Signature

Initial	Signature	Initial	Signature	Initial	Signature
5	Sgt Davidson	4	Sgt Petrey	7	Kim
25	Spence				

DATE RECEIVED:_____
TIME RECEIVED:_____
RECEIVED BY:_____

CHAMBERS COUNTY DETENTION FACILITY
MEDICAL REQUEST FORM

NAME: Chris McCully NUMBER 6847 CELL# I3 DATE: 2-24-03

WHAT IS YOU MEDICAL PROBLEM: I can't sleep and my ribs still ache.

I UNDERSTAND THE CHAMBERS COUNTY DETENTION FACILITY CHARGES A CO-PAY FOR THESE SERVICES. I ALSO UNDERSTAND ALL MEDICAL SERVICES RENDERED WHILE AN INMATE WILL BE CHARGED BACK TO ME AS RESTITUTION. CO-PAYS ARE, TO SEE THE NURSE $2.00 - DOCTOR $5.00 PRESCRIPTIONS $1.00 EACH, THESE CHARGE WILL BE DEDUCTED FROM MY COMMISSARY ACCOUNT. BEING INDIGENT DOES NOT STOP ME FROM SEEKING MEDICAL ATTENTION.

Chris McCully
INMATE SIGNATURE

NURSE/DOCTOR
NOTES: Seen by Dr Guin

2-27-03
DATE

E Baltrip
NURSE/DOCTOR SIGNATURE

NURSE ~~0~~ DOCTOR ✓ PRESCRIPTIONS _____
$2.00 $5.00 AT $1.00

5.00

TOTAL INMATE CHARGES $ 7.00 BY: JW
DATE: 3-10-03
CLERK

CHAMBERS COUNTY DETENTION FACILITY

MEDICAL TREATMENT REFUSAL

I, Chris McCullough Master ID# 6547, refuse medical treatment provided by _____ whom I was referred/requested to see at the Chambers County Detention Facility on _____.

Notes: Cell Gone Out

_____ Chris M.
Date Inmate Name

1-30-08 LeQuoia M. Brown
Date Officer Signature

DATE RECEIVED: 2-5-03
TIME RECEIVED: 15:04
RECEIVED BY: D24 - Anderson

CHAMBERS COUNTY DETENTION FACILITY
MEDICAL REQUEST FORM

NAME: Chris McCullough NUMBER 6847 CELL# G-6 DATE: 2-05-03

WHAT IS YOU MEDICAL PROBLEM: I have bruised ribs need medical attention badly.

I UNDERSTAND THE CHAMBERS COUNTY DETENTION FACILITY CHARGES A CO-PAY FOR THESE SERVICES. I ALSO UNDERSTAND ALL MEDICAL SERVICES RENDERED WHILE AN INMATE WILL BE CHARGED BACK TO ME AS RESTITUTION. CO-PAYS ARE, TO SEE THE NURSE $2.00 - DOCTOR $5.00 PRESCRIPTIONS $1.00 EACH, THESE CHARGE WILL BE DEDUCTED FROM MY COMMISSARY ACCOUNT. BEING INDIGENT DOES NOT STOP ME FROM SEEKING MEDICAL ATTENTION.

Chris McCullough
INMATE SIGNATURE

NURSE/DOCTOR NOTES: Seen

2-7-03
DATE

NURSE/DOCTOR SIGNATURE

NURSE ✓ $2.00 DOCTOR _____ $5.00 PRESCRIPTIONS _____ AT $1.00

TOTAL INMATE CHARGES $2.00 BY: 1
CLERK

DATE: 2-10-03

Case 3:05-cv-01163-WKW-SRW Document 32-13 Filed 07/28/2008 Page 15 of 24

Chambers County Detention Facility Montly Medication Sheet

Code = R-Refused D/C-Discontinued O-Ordered

Last Name: McCullough | First Name: Chris | Middle Name: | Master ID#: | Room No.: 2 | Month: Jan | Year: 2003

Medications	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Doxepin 50 mg 1 cap at bedtime	9558251	7	6	6	6	6	4	8	4	4	5	5	5	5	7	7	7	7	5	5	5	5	7	7	7	7	5	5	5	7	7	7

Initial Medication and Identify Initials Below with Signature

Initial	Signature	Initial	Signature	Initial	Signature
6	Sgt. Wright	5	Sgt. Davidson	4	Sgt. Nelson
				7	Sgt.

DATE RECEIVED:_____
TIME RECEIVED: _____
RECEIVED BY: _____

CHAMBERS COUNTY DETENTION FACILITY
MEDICAL REQUEST FORM

NAME: Chris McGilvary NUMBER D-6 CELL# 6 DATE: 1-19-2003

WHAT IS YOU MEDICAL PROBLEM: Have 2 cold

I UNDERSTAND THE CHAMBERS COUNTY DETENTION FACILITY CHARGES A CO-PAY FOR THESE SERVICES. I ALSO UNDERSTAND ALL MEDICAL SERVICES RENDERED WHILE AN INMATE WILL BE CHARGED BACK TO ME AS RESTITUTION. CO-PAYS ARE, TO SEE THE NURSE $2.00 - DOCTOR $5.00 PRESCRIPTIONS $1.00 EACH, THESE CHARGE WILL BE DEDUCTED FROM MY COMMISSARY ACCOUNT. BEING INDIGENT DOES NOT STOP ME FROM SEEKING MEDICAL ATTENTION

Chris McGilvary
INMATE SIGNATURE

NURSE/DOCTOR NOTES: Refused

1-30-03
DATE

EBeltRe
NURSE/DOCTOR SIGNATURE

NURSE _____ $2.00 DOCTOR _____ $5.00 PRESCRIPTIONS _____ AT $1.00

TOTAL INMATE CHARGES $_____ BY: _____
CLERK
DATE: _____

Need Signed Refusal Slip

Case 3:05-cv-01163-WKW-SRW Document 32-13 Filed 07/28/2008 Page 17 of 24

Chambers County Detention Facility Montly Medication Sheet

Code = R-Refused D/C-Discontinued O-Ordered

Last Name: McCullough | First Name: Chris | Middle Name: | Master ID#: 6847 | Room No.: D | Month: Dec | Year: 2007

Medications	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Doxepin 50 mg 1 cap at bedtime 958 251	7pm																		26	6	20	8		4	4	6	6	6	6	4	4	4

Initial Medication and Identify Initials Below with Signature

Initial	Signature	Initial	Signature	Initial	Signature
lo	Lt. Wright	20	[illegible]	4	Sgt [illegible]

DATE RECEIVED:_____
TIME RECEIVED: _____
RECEIVED BY: _____

CHAMBERS COUNTY DETENTION FACILITY
MEDICAL REQUEST FORM

NAME: Chris McCully NUMBER 6847 CELL# D-6 DATE: _____

WHAT IS YOU MEDICAL PROBLEM: Can't sleep hear voices

I UNDERSTAND THE CHAMBERS COUNTY DETENTION FACILITY CHARGES A CO-PAY FOR THESE SERVICES. I ALSO UNDERSTAND ALL MEDICAL SERVICES RENDERED WHILE AN INMATE WILL BE CHARGED BACK TO ME AS RESTITUTION. CO-PAYS ARE, TO SEE THE NURSE $2.00 - DOCTOR $5.00 PRESCRIPTIONS $1.00 EACH, THESE CHARGE WILL BE DEDUCTED FROM MY COMMISSARY ACCOUNT. BEING INDIGENT DOES NOT STOP ME FROM SEEKING MEDICAL ATTENTION

Chris McCulley
INMATE SIGNATURE

NURSE/DOCTOR NOTES: Seen by Dr Quin

12-19-02
DATE

E Rockey
NURSE/DOCTOR SIGNATURE

NURSE _____ DOCTOR ✓ PRESCRIPTIONS _____
$2.00 $5.00 AT $1.00

TOTAL INMATE CHARGES $ 5.00 BY: L
DATE: 12/19/02 CLERK

DATE RECEIVED: _____
TIME RECEIVED: _____
RECEIVED BY: _____

CHAMBERS COUNTY DETENTION FACILITY
MEDICAL REQUEST FORM

NAME: Chris McCully NUMBER 6847 CELL# E-Block DATE: 8-14-2002

WHAT IS YOU MEDICAL PROBLEM: My Left arm is hurt like its sprung

I UNDERSTAND THE CHAMBERS COUNTY DETENTION FACILITY CHARGES A CO-PAY FOR THESE SERVICES. I ALSO UNDERSTAND ALL MEDICAL SERVICES RENDERED WHILE AN INMATE WILL BE CHARGED BACK TO ME AS RESTITUTION. CO-PAYS ARE, TO SEE THE NURSE $2.00 - DOCTOR $5.00 PRESCRIPTIONS $1.00 EACH, THESE CHARGE WILL BE DEDUCTED FROM MY COMMISSARY ACCOUNT. BEING INDIGENT DOES NOT STOP ME FROM SEEKING MEDICAL ATTENTION

Chris McCullough
INMATE SIGNATURE

NURSE/DOCTOR NOTES: Seen by Dr Quin

8-15-02
DATE

[signature]
NURSE/DOCTOR SIGNATURE

NURSE ✓ $2.00 DOCTOR _____ $5.00 PRESCRIPTIONS _____ AT $1.00

TOTAL INMATE CHARGES $ 2.00 BY: [signature]
DATE: _____ CLERK

DATE RECEIVED:_____
TIME RECEIVED: _____
RECEIVED BY: _____

CHAMBERS COUNTY DETENTION FACILITY
MEDICAL REQUEST FORM

NAME: Chris McCulley NUMBER 6847 CELL# E DATE: 7-31-02

WHAT IS YOU MEDICAL PROBLEM: Left arm feel sprung

I UNDERSTAND THE CHAMBERS COUNTY DETENTION FACILITY CHARGES A CO-PAY FOR THESE SERVICES. I ALSO UNDERSTAND ALL MEDICAL SERVICES RENDERED WHILE AN INMATE WILL BE CHARGED BACK TO ME AS RESTITUTION. CO-PAYS ARE, TO SEE THE NURSE $2.00 - DOCTOR $5.00 PRESCRIPTIONS $1.00 EACH, THESE CHARGE WILL BE DEDUCTED FROM MY COMMISSARY ACCOUNT. BEING INDIGENT DOES NOT STOP ME FROM SEEKING MEDICAL ATTENTION

Chris McCulley

INMATE SIGNATURE

NURSE/DOCTOR
NOTES: Refused Appt. C.O. Ronie S

DATE

NURSE/DOCTOR SIGNATURE

NURSE _____ $2.00 DOCTOR _____ $5.00 PRESCRIPTIONS _____ AT $1.00

TOTAL INMATE CHARGES $_____ BY: _____
DATE: _____ CLERK

E - 5

DATE RECEIVED: 7/17/02
TIME RECEIVED: 2500.
RECEIVED BY: C/O Dowdell

CHAMBERS COUNTY DETENTION FACILITY
MEDICAL REQUEST FORM

NAME: Chris McCullough NUMBER 6847 CELL# E DATE: 7-17-2002

WHAT IS YOU MEDICAL PROBLEM: Arm hurting

I UNDERSTAND THE CHAMBERS COUNTY DETENTION FACILITY CHARGES A CO-PAY FOR THESE SERVICES. I ALSO UNDERSTAND ALL MEDICAL SERVICES RENDERED WHILE AN INMATE WILL BE CHARGED BACK TO ME AS RESTITUTION. CO-PAYS ARE, TO SEE THE NURSE $2.00 - DOCTOR $5.00 PRESCRIPTIONS $1.00 EACH, THESE CHARGE WILL BE DEDUCTED FROM MY COMMISSARY ACCOUNT. BEING INDIGENT DOES NOT STOP ME FROM SEEKING MEDICAL ATTENTION

Chris McCullough
INMATE SIGNATURE

NURSE/DOCTOR
NOTES: Refused per C.O. Thrower

DATE

NURSE/DOCTOR SIGNATURE

NURSE _____ DOCTOR _____ PRESCRIPTIONS _____
$2.00 $5.00 AT $1.00

TOTAL INMATE CHARGES $_____ BY: _____
DATE: _____ CLERK

HIV SEROLOGY 86701
WESTERN BLOT 86689

ALABAMA DEPARTMENT OF PUBLIC HEALTH
BUREAU OF CLINICAL LABORATORIES

I.D. NUMBER A 076473

PLEASE USE A BLACK PEN

Patient's Last Name: McLaughlin | Patient's First Name: Christopher | MI:

Address: 105 Alabama Ave | Apt.:

City: Lafayette | State: AL | Zip: 36862

Phone: ( ) - -

PLACE LABEL INSIDE RECTANGLE

Counselor (Initials): CH

Date Collected: 05 / 15 / 02

EIA Results: Indicated by Marked	WESTERN BLOT
(•) Negative	( ) Negative
( ) Unsatisfactory	( ) Indeterminate
( ) Positive	( ) Positive
	( ) Not Done

RACE: W (•) B ( ) H ( ) A ( ) I ( ) U ( )
SEX: M (•) F ( )
DOB (mmddyyyy): 11 / 20 / 1972

ANALYST INITIALS:

DATE REPORTED: 05 / 17 / 02

- [ ] Birmingham
- [ ] Decatur
- [ ] Dothan
- [ ] Mobile
- [x] Montgomery

Provider: PHA 6
Address: Box 4699
City: Anniston | State: AL | Zip: 36201

SITE CODE: 02 | CNTY: 09

County Health Dept. CHR Number:

Social Security Number: - -

Medicaid Number:

Provider Number: 09C686220

Has Patient Had a Previous Positive or Indeterminate Western Blot?
( ) No ( ) Yes ( ) Unknown

Date: / /

SYPHILIS SEROLOGY 86592 86593 86781

ALABAMA DEPARTMENT OF PUBLIC HEALTH
BUREAU OF CLINICAL LABORATORIES

Lab # [illegible] REV 15 '02

Name: Last McLaughlin | First Christopher | MI | Date Received MM DD YY

County Health Dept. CHR Number | Date of Birth: 11 27 72 | Sex: M | Race: B

Medicaid Number

Social Security Number | Date Collected: 05 15 02

Patient Address: 105 Alabama Ave Lafayette

Specimen: [ ] Prenatal [ ] Spinal Fluid [ ] Blood

RESULTS — Shaded area for Laboratory use only

VDRL [x] TP-PA [ ] Nonreactive
[ ] Weakly Reactive
[ ] [ ] Unsatisfactory:
[ ] ___ dils [ ] Reactive

If private insurance available, send copy of card.

Mail Report to: PUBLIC HEALTH
AREA VI
P. O. Box 4699
Anniston, AL 36202

09C686220
Provider Number

[ ] History of treatment for syphilis

Date Reported: MM DD YY

[ ] B'ham [ ] Decatur [ ] Dothan [ ] Mobile [x] Mont.

ADPH-F-BCL-76/REV. 4-00

1997321024

REPORT COPY
Return to provider

ADPH-CL-109 / REV 01-01

LANETT POLICE DEPARTMENT

STATEMENT OF: Sam Thrower

ADDRESS: Lanett Fire Dept.

PHONE NUMBER: 644-5230

Date: 8/22/00

Time: 0800

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With regards to Mr. Chris McCullough, myself and my partner of Lanett Fire & EMS treated the above for a laceration to his (L) forearm. We bandaged his forearm with gauze and Kling. Bleeding was controlled. Otherwise stable, Mr. McCullough refused further treatment or transport. No further interventions by EMS

Firefighter / Paramedic

EMSF-9351019

LANIER MEMORIAL HOSPITAL
EMERGENCY DEPARTMENT

LACERATION/WOUND CARE INSTRUCTIONS

1. KEEP WOUND CLEAN AND DRY.

2. CLEAN DAILY WITH (PEROXIDE) (BETADINE) .

3. SEE PRIVATE PHYSICIAN OR RETURN TO EMERGENCY ROOM.
   A. WOUND BECOMES SWOLLEN OR HOT.
   B. WOUND BREAKS OPEN, DRAINS, OR HAS BAD ODOR.
   C. SORE GLANDS OR RED STREAKS DEVELOP.
   D. DRESSING BECOMES DIRTY OR BLOOD SOAKED.
   E. OTHER PROBLEMS.

4. KEEP INJURED PART ELEVATED TO PREVENT SWELLING FOR 4-5 DAYS.

5. MAY HAVE _____ TABLETS , EVERY _____ HOURS AS NEEDED FOR PAIN.

6. YOU MAY RETURN TO THE EMERGENCY ROOM FOR REMOVAL OF STITCHES AT NO ADDITIONAL CHARGE .
   YOUR STITCHES SHOULD BE REMOVED IN 7-10 DAYS.

ADDITIONAL INSTRUCTIONS

_____

_____

_____

I HAVE RECEIVED AND UNDERSTAND THE ABOVE INSTRUCTIONS.

X [redacted]

SIGNATURE RELATIONSHIP

8/7/03

DATE

[redacted]

NURSE

McCullough, Chris

PATIENT NAME

21994

PATIENT NUMBER